		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016220

Facility Name: APOSTOLIC CHRISTIAN TIMBER RIDGE

Address: 2125 VETERANS ROAD (Number) MORTON (City) 61550 (Zip Code)

County: TAZEWELL

Telephone Number: 309-266-9781 **Fax #** 309-266-9468

IDPA ID Number: 23-7033585-001

Date of Initial License for Current Owners: 10/10/71

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT		[ ]	PROPRIETARY		[ ]	GOVERNMENTAL
	[X]	Charitable Corp.		[ ]	Individual		[ ] State
	[ ]	Trust		[ ]	Partnership		[ ] County
IRS Exemption Code	501(c)(3)			[ ]	Corporation		[ ] Other
				[ ]	"Sub-S" Corp.		
				[ ]	Limited Liability Co.		
				[ ]	Trust		
				[ ]	Other		

In the event there are further questions about this report, please contact:
Name: MATT STEFFEN **Telephone Number:** 309-266-9781

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) DANIEL SCHUMACHER
(Title) DIRECTOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) JEROME D. MCDADE, SHAREHOLDER
(Firm Name & Address) HEINOLD-BANWART, LTD. 2400 N. MAIN, EAST PEORIA, IL 61611
(Telephone) 309-694-4251 Fax # 309-694-4202

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/1/94

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	98	Intermediate/DD	98	35,770	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	32,412			32,412	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,412			32,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.61%

D. How many bed-hold days during this year were paid by Public Aid?
321 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/71

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGI # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	243,596	12,224	3,802	259,622	(141)	259,481		259,481			1
2	Food Purchase		153,070		153,070		153,070		153,070			2
3	Housekeeping	96,014	8,894		104,908		104,908		104,908			3
4	Laundry	110,149	12,313		122,462	418	122,880		122,880			4
5	Heat and Other Utilities			70,835	70,835		70,835		70,835			5
6	Maintenance	98,972	16,872	24,799	140,643	2,228	142,871	(20,998)	121,873			6
7	Other (specify):*											7
8	**TOTAL General Services**	548,731	203,373	99,436	851,540	2,505	854,045	(20,998)	833,047			8
	B. Health Care and Programs											
9	Medical Director			1,332	1,332		1,332		1,332			9
10	Nursing and Medical Records	739,488	173,735	52,814	966,037	(24,116)	941,921	(11,144)	930,777			10
10a	Therapy	1,557,579	5,084	49,322	1,611,985	(1,797)	1,610,188		1,610,188			10a
11	Activities	218,745	6,646		225,391	90	225,481		225,481			11
12	Social Services	154,464	1,980	7,204	163,648	(12,243)	151,405		151,405			12
13	Nurse Aide Training	46,385			46,385	39,084	85,469		85,469			13
14	Program Transportation			37,916	37,916	(7,258)	30,658	(11,144)	19,514			14
15	Other (specify):* Day Progamming	85,395	1,886		87,281		87,281	(87,281)				15
16	**TOTAL Health Care and Programs**	2,802,056	189,331	148,588	3,139,975	(6,240)	3,133,735	(109,569)	3,024,166			16
	C. General Administration											
17	Administrative	75,848			75,848	(337)	75,511		75,511			17
18	Directors Fees											18
19	Professional Services			17,151	17,151		17,151		17,151			19
20	Dues, Fees, Subscriptions & Promotions			20,719	20,719		20,719	(2,885)	17,834			20
21	Clerical & General Office Expenses	99,746	32,231	14,136	146,113	1,651	147,764		147,764			21
22	Employee Benefits & Payroll Taxes			862,588	862,588		862,588	(20,702)	841,886			22
23	Inservice Training & Education			8,915	8,915		8,915		8,915			23
24	Travel and Seminar			4,533	4,533		4,533	(3,483)	1,050			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			29,320	29,320		29,320		29,320			26
27	Other (specify):*			16,886	16,886	(12,675)	4,211	(4,211)				27
28	**TOTAL General Administration**	175,594	32,231	974,248	1,182,073	(11,361)	1,170,712	(31,281)	1,139,431			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,526,381	424,935	1,222,272	5,173,588	(15,096)	5,158,492	(161,848)	4,996,644			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE #0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			141,809	141,809		141,809	(22,268)	119,541			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,176	4,176	(1,274)	2,902		2,902			35
36	Other (specify):*											36
37	**TOTAL Ownership**			145,985	145,985	(1,274)	144,711	(22,268)	122,443			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					7,258	7,258	(7,258)				38
39	Ancillary Service Centers					9,112	9,112		9,112			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			249,248	249,248		249,248		249,248			42
43	Other (specify):*			2,870	2,870		2,870		2,870			43
44	**TOTAL Special Cost Centers**			252,118	252,118	16,370	268,488	(7,258)	261,230			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,526,381	424,935	1,620,375	5,571,691		5,571,691	(191,374)	5,380,317			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (20,998)	6	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(87,281)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,211)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,885)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(75,999)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (191,374)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (191,374)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 7,258	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 7,258		47

STATE OF ILLINOIS

APOSTOLIC CHRISTIAN TIMBER RIDGE

ID# 0016220

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset day training transportation income	$ (11,144)	10	1
2	Offset day training transportation income	(11,144)	14	2
3	Out-of-state travel	(3,483)	24	3
4	Depreciation of non-care vehicles	(22,268)	30	4
5	Offset medically necessary transp. income	(7,258)	38	5
6	Benefits allocated to day programming	(20,702)	22	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(75,999)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE **#** 0016220 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(20,998)	0	0	0	0	0	0	0	0	0	0	(20,998)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(20,998)	0	0	0	0	0	0	0	0	0	0	(20,998)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(11,144)	0	0	0	0	0	0	0	0	0	0	(11,144)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(11,144)	0	0	0	0	0	0	0	0	0	0	(11,144)	14
15	Other (specify):*	(87,281)	0	0	0	0	0	0	0	0	0	0	(87,281)	15
16	**TOTAL Health Care and Programs**	(109,569)	0	0	0	0	0	0	0	0	0	0	(109,569)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,885)	0	0	0	0	0	0	0	0	0	0	(2,885)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(20,702)	0	0	0	0	0	0	0	0	0	0	(20,702)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,483)	0	0	0	0	0	0	0	0	0	0	(3,483)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,211)	0	0	0	0	0	0	0	0	0	0	(4,211)	27
28	**TOTAL General Administration**	(31,281)	0	0	0	0	0	0	0	0	0	0	(31,281)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(161,848)	0	0	0	0	0	0	0	0	0	0	(161,848)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(22,268)	0	0	0	0	0	0	0	0	0	0	(22,268)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(22,268)	0	0	0	0	0	0	0	0	0	0	(22,268)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(7,258)	0	0	0	0	0	0	0	0	0	0	(7,258)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(7,258)	0	0	0	0	0	0	0	0	0	0	(7,258)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(191,374)	0	0	0	0	0	0	0	0	0	0	(191,374)	45

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Apostolic Christian Home for the Handicappe	100	Oakwood Estate	Morton	Community Residentia	Morton	Service for the
Apostolic Christian Home for the Handicappe	100	Linden Estate	Morton	Services		Disabled

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDG # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Edward Sauder	Chairman	Director	0.00		0.5			$		1
2	John Knobloch	Vice Chairman	Director	0.00		0.5					2
3	Dan Schumacher	Sec/ Treasurer	Director	0.00		1					3
4	Jerry Christensen	Director	Director	0.00		0.5					4
5	Ron Gasser	Director	Director	0.00	478	0.5		Travel	1,391	line 24; col.3	5
6	Jerry Kieser	Director	Director	0.00		0.5					6
7	Keith Pflum	Director	Director	0.00	106	0.5		Travel	308	line 24; col.3	7
8	Richard Steffen	Director	Director	0.00		0.5					8
9	Warren Zahner	Director	Director	0.00	416	0.5		Travel	1,214	line 24; col.3	9
10	Michael Dubach	Director	Director	0.00	196	0.5		Travel	570	line 24; col.3	10
11											11
12											12
13								TOTAL	$ 3,483		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME APOSTOLIC CHRISTIAN TIMBER RIDGE COUNTY TAZEWELL

FACILITY IDPH LICENSE NUMBER 0016220

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,135 B. General Construction Type: Exterior Brick Frame Fireproof Building Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

Oakwood Estate (IDPA #0033712) is located adjacent to this property.
Type of business - Nursing Home (16 bed, ICF/DD)
Square footage - Land 91,781; Building - 7,140 sq. ft.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	1,345,699	1969	$ 54,397	1
2					2
3	TOTALS	1,345,699		$ 54,397	3

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	44			1971	$ 650,091	$ 16,252	40	$ 16,252	$	$	4
5	54			1978	1,016,439	25,411	40	25,411			5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinklers, smoke detectors			1977	15,687	392	40	392			9
10	Conference room			1979	20,973	524	40	524			10
11	Front entrance			1981	6,308	158	40	158			11
12	Sprinklers, security system			1982	7,002	175	40	175			12
13	Energy system			1983	5,725	143	40	143			13
14	Interior remodeling			1984	8,655	216	40	216			14
15	Storage addition			1985	25,692	642	40	642			15
16	Windows, furnace, improvements			1986	11,626	291	40	291			16
17	Redocorating, furnace, improvements			1987	42,953	1,074	40	1,074			17
18	Compressor, addition, office			1988	28,487	712	40	712			18
19	Office, patio, improvements			1988	26,716	668	40	668			19
20	Office, patio, improvements			1989	37,019	925	40	925			20
21	Flooring			1990	23,903	598	40	598			21
22	Roof, ceiling, flooring			1991	11,832	296	40	296			22
23	Flooring & improvements			1992	14,999	375	40	375			23
24	Roof			1994	31,810	795	40	795			24
25	Roofing			1995	17,217	430	40	430			25
26	Heat pump			1995	5,208	130	40	130			26
27	Remodel living room, lumber, windows			1995	10,408	260	40	260			27
28	Patio cover			1996	3,750	94	40	94			28
29	Magnetic Doors			1996	3,321	83	40	83			29
30	Floor covering			1997	850	21	40	21			30
31	Heat pumps & air conditioning units			1997	22,367	559	40	559			31
32	Heat pump & a/c installation			1998	2,696	67	40	67			32
33	Floor covering			1998	985	25	40	25			33
34	Wallpaper			1998	924	23	40	23			34
35	Bathroom remodeling			1998	1,657	41	40	41		1,260,091	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Patient hall bathroom	1999	$ 3,610	$ 90	40	$ 90	$	$ 315	37
38	Sprinkler heads	1999	3,690	92	40	92		322	38
39	Automatic doors	1999	9,356	234	40	234		819	39
40	Duct work	1999	1,082	27	40	27		95	40
41									41
42	Air conditioner	2000	1,882	47	40	47		118	42
43	Heat pump	2000	3,100	78	40	78		195	43
44	Automatic rear door	2000	1,773	44	40	44		110	44
45	Power panels/ generator	2000	14,000	350	40	350		875	45
46	Office window	2000	1,057	26	40	26		65	46
47	Exhaust fan	2000	580	15	40	15		36	47
48	Dining room remodeling	2000	10,565	264	40	264		660	48
49	Fire alarm relay	2000	2,400	60	40	60		150	49
50	Bathrooms - remodel	2000	22,147	554	40	554		1,385	50
51	Water coolers	2000	2,701	68	40	68		170	51
52	Roof repairs	2000	1,133	28	40	28		70	52
53									53
54	OT/PT decorating	2001	1,111	74	15	74		111	54
55	Slab jacking	2001	1,312	87	15	87		131	55
56	Roof replacement	2001	21,380	1,425	15	1,425		2,138	56
57	Roof replacement	2001	16,779	1,119	15	1,119		1,678	57
58	Lobby carpet and redecorating	2001	11,774	785	15	785		1,177	58
59	Dining room remodeling	2001	3,308	221	15	221		331	59
60	Additional QMRP (by activity rm.)	2001	2,393	160	15	160		240	60
61	Pipe insulation	2001	2,613	174	15	174		261	61
62	North resident renovation	2001	4,632	309	15	309		463	62
63	Activity room remodeling	2001	1,903	127	15	127		190	63
64	South whirlpool room	2001	2,676	178	15	178		267	64
65	Hand rails	2001	2,844	190	15	190		285	65
66	South living remodeling	2001	5,107	340	15	340		510	66
67	Hot water heater/ plumbing	2001	13,510	901	15	901		1,351	67
68	Heat pump	2001	4,694	313	15	313		469	68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,230,412	$ 59,760		$ 59,760	$	$ 1,275,078	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,230,412	$ 59,760		$ 59,760	$	$ 1,275,078	1
2	Key pad entry for south end	2002	2,500	83	15	83		83	2
3	Water heater plumbing	2002	706	24	15	24		24	3
4	Water heaters	2002	8,482	283	15	283		283	4
5	Lighting - small office in lobby	2002	545	18	15	18		18	5
6	Air conditioner - south living room	2002	3,196	107	15	107		107	6
7									7
8	Land Improvements:								8
9	Improvements	1971	55,213		20			55,213	9
10	Improvements	1973	4,214		20			4,214	10
11	Drive, fence	1976	6,847		20			6,847	11
12	Landscaping	1979	30,551		20			30,551	12
13	Various	1980	15,117		20			15,117	13
14	Picnic area	1981	1,401		20			1,401	14
15	Fence	1983	5,880	294	20	294		5,735	15
16	Fence	1983	595	28	20	28		534	16
17	Patio	1984	978	50	20	50		881	17
18	Blacktop driveways	1985	22,000	1,100	20	1,100		16,597	18
19	South courtyard	1990	1,409	70	20	70		903	19
20	Irrigation, north courtyard	1989	2,585	129	20	129		1,677	20
21	Driveway, landscaping	1993	10,459	523	20	523		5,566	21
22	Sewer repair	1994	6,700	335	20	335		3,015	22
23	Tile and asphalt	1995	2,011	101	20	101		782	23
24	Asphalt	1997	15,136	757	20	757		4,541	24
25	Parking lot	1998	39,261	1,964	20	1,964		9,817	25
26	Repair asphalt	1999	3,500	175	20	175		613	26
27	Parking lot lights & installation	1999	4,000	200	20	200		700	27
28	Blacktop ramp at rear entrance	2001	770	77	10	77		116	28
29	Landscape drive entrance	2001	1,447	96	15	96		144	29
30	Landscape around building	2001	1,230	82	15	82		123	30
31	Various	1988	3,188		20			3,188	31
32	Sidewalk/ entry apron	2002	11,816	394	15	394		394	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,492,149	$ 66,650		$ 66,650	$	$ 1,444,262	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,492,149	$ 66,650		$ 66,650	$	$ 1,444,262	1
2	Garage	1988	22,885	573	40	573			2
3	Storage Building	1973	9,065	226	40	226			3
4	Storage Bldg - addition	1981	4,660	117	40	117			4
5	Storage Bldg - addition	1982	21,496	538	40	538			5
6	Storage Bldg - addition	1983	126	3	40	3			6
7	Storage Bldg - improvements	1985	842	21	40	21			7
8	Garage door	1998	667	44	15	44			8
9	Garage lights	2001	1,400	93	15	93			9
10	Garage door	2002	594	20	15	20		29,535	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,553,884	$ 68,285		$ 68,285	$	$ 1,473,797	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 423,408	$ 47,074	$ 47,074	$		$ 212,367	71
72	Current Year Purchases	43,516	3,033	3,033			3,033	72
73	Fully Depreciated Assets	371,545	1,149	1,149			371,545	73
74								74
75	TOTALS	$ 838,469	$ 51,256	$ 51,256	$		$ 586,945	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,446,750	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 119,541	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,060,742	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Fully depreciated vehicles	$ 179,579	$ 2,085	$ 179,579	86
87	Capitalized repairs	31,818	4,966	14,584	87
88	1997 F250 Truck; 1998	23,102	4,620	21,525	88
89	High Top Van; 2000	34,410	6,882	16,631	89
90	1998 Ford Titan Van; 2000	18,577	3,715	8,978	90
91	TOTALS	$ 287,486	$ 22,268	$ 241,297	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,902 Description: Food pump, oxygen concentrator
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	690	2,414		3,104
3	Classroom Wages (a)	2,958	9,733		12,691
4	Clinical Wages (b)	5,916	27,778		33,694
5	In-House Trainer Wages (c)	7,995	27,985		35,980
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 17,559	$ 67,910	$	$ 85,469
10	SUM OF line 9, col. 1 and 2 (e)	$ 85,469			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	49
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	14
2. From other facilities (f)	
TOTAL TRAINED	63

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 117,479	$ 119,279	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,000)	1,138,628	1,493,939	3
4	Supply Inventory (priced at 41,627)	41,627	48,435	4
5	Short-Term Investments	3,253,388	3,253,388	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,690	11,930	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee & other receivables	105,856	105,993	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,665,668	$ 5,032,964	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	300,705	633,069	13
14	Buildings, at Historical Cost	2,307,576	3,626,650	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,125,953	1,461,847	16
17	Accumulated Depreciation (book methods)	(2,304,590)	(2,988,566)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		46,121	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(46,121)	20
21	Restricted Funds	3,022,439	3,022,439	21
22	Other Long-Term Assets (specify):	3,016,138		22
23	Other(specify): Cash value life insurance	14,335	14,335	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,482,556	$ 5,769,774	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,148,224	$ 10,802,738	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 62,286	$ 68,304	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	242,390	319,891	30
31	Accrued Taxes Payable (excluding real estate taxes)	45,191	45,191	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	83,032	111,000	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 432,899	$ 544,386	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 432,899	$ 544,386	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,715,325	$ 10,258,352	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,148,224	$ 10,802,738	48

***(See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,390,323	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,390,323	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	325,002	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 325,002	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,715,325	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,500,132	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,500,132	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	72,813	10
11	Nurses Aide Training Reimbursements	47,747	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,716	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 127,276	23
	D. Non-Operating Revenue		
24	Contributions	720,760	24
25	Interest and Other Investment Income***	223,363	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 944,123	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached schedule**	325,162	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 325,162	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,896,693	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	851,540	31
32	Health Care	3,139,975	32
33	General Administration	1,182,073	33
	B. Capital Expense		
34	Ownership	145,985	34
	C. Ancillary Expense		
35	Special Cost Centers	2,870	35
36	Provider Participation Fee	249,248	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,571,691	40
41	**Income before Income Taxes (line 30 minus line 40)****	325,002	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 325,002	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,766	2,086	$ 67,456	$ 32.34	1
2	Assistant Director of Nursing	1,607	1,842	40,533	22.00	2
3	Registered Nurses	14,986	15,102	311,791	20.65	3
4	Licensed Practical Nurses	16,488	16,579	319,708	19.28	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	5,457	5,457	46,385	8.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,858	2,086	37,167	17.82	9
10	Activity Assistants	17,039	18,176	181,578	9.99	10
11	Social Service Workers	1,325	1,452	14,259	9.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,805	2,086	29,811	14.29	14
15	Cook Helpers/Assistants	21,120	21,937	213,785	9.75	15
16	Dishwashers					16
17	Maintenance Workers	5,727	5,854	98,972	16.91	17
18	Housekeepers	8,896	9,347	96,014	10.27	18
19	Laundry	10,058	10,581	110,149	10.41	19
20	Administrator	1,265	1,605	75,848	47.26	20
21	Assistant Administrator					21
22	Other Administrative	3,033	2,690	52,020	19.34	22
23	Office Manager	1,848	2,080	39,211	18.85	23
24	Clerical	884	1,280	8,515	6.65	24
25	Vocational Instruction	1,507	1,716	25,369	14.78	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,001	8,956	140,205	15.65	28
29	Resident Services Coordinator	1,830	2,088	52,614	25.20	29
30	Habilitation Aides (DD Homes)	114,103	119,376	1,298,372	10.88	30
31	Medical Records					31
32	Other Health Ca OT/PT/Speech	11,966	12,725	181,224	14.24	32
33	Other(specify) Day Program	6,815	7,129	85,395	11.98	33
34	TOTAL (lines 1 - 33)	260,384	272,230	$ 3,526,381 *	$ 12.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	88	$ 3,802	1-3	35
36	Medical Director	flat fee	1,332	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat fee	2,679	10-3	39
40	Physical Therapy Consultant	55	3,293	10a-3	40
41	Occupational Therapy Consultant	82	4,333	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	105	6,789	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	42	3,404	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	372	$ 25,632		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,266	$ 40,890	10-3	50
51	Licensed Practical Nurses	297	9,245	10-3	51
52	Nurse Aides	1,928	34,907	10a-3	52
53	TOTAL (lines 50 - 52)	3,491	$ 85,042		53

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ron Messner	Administrator	0	$ 75,848
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,848

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Howard & Howard	Legal	$ 353
Heinold Banwart. Ltd.	Acctg. & Consulting	16,798
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,151

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,125
Unemployment Compensation Insurance	827
FICA Taxes	263,808
Employee Health Insurance	374,532
Employee Meals	49,433
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	91,221
Employee Physicals	2,211
Employee Promotion	11,431
Benefits allocated to day programming	(20,702)
TOTAL (agree to Schedule V, line 22, col.8)	$ 841,886

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 35
Advertising: Employee Recruitment	9,337
Health Care Worker Background Check	853
(Indicate # of checks performed 71)	
Vehicle & other licenses	937
Promotion	2,510
IHCA dues	4,155
Other dues & subscriptions	2,245
Chamber of Commerce dues	375
Driving records verification	272
Less: Public Relations Expense	(2,885)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,834

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Board of Directors travel	3,483
In-State Travel	
Administration travel	1,050
Seminar Expense	
Less out of state travel	(3,483)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,050

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 07/01/01 Ending: 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn - $4,155**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **57,263** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **249,248**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **Yes** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **49,433** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No, adjusted out**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **7,258**
c. What percent of all travel expense relates to transportation of nurses and patients? **89%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **65,555**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Heinold-Banwart, Ltd.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain. **Report - Consolidated basis only**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Apostolic Christian Timber Ridge
FYE 6/30/2002 #016220
Subschedules

Schedule V - Costs per General Ledger

Lines	Description	Amount
43	Facility Bulletin	2,870
	Other Expenses	2,870

Schedule V - Reclassifications

Lines	Description	Amount Increase	Amount Decrease
21	Communication equipment renta	1,274	
35	Communication equipment renta		1,274
11	Donated labor	226	
4	Donated labor	418	
6	Donated labor	2,448	
21	Donated labor	377	
10a	Donated labor	58	
12	Donated labor	36	
27	Donated labor		3,563
38	Medically necessary transportatior	7,258	
14	Medically necessary transportatior		7,258
13	Nurse aid trainer wages	35,980	
1	Nurse aid trainer wages		141
6	Nurse aid trainer wages		220
10	Nurse aid trainer wages		21,012
10a	Nurse aid trainer wages		1,855
11	Nurse aid trainer wages		136
12	Nurse aid trainer wages		12,279
17	Nurse aid trainer wages		337
13	Nurse aid training supplies	3,104	
10	Nurse aid training supplies		3,104
39	Dental costs	9,112	
27	Dental costs		9,112
		60,291	60,291

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	$ 3,563
Department	Time in Hours	Time in Dollars
Activities	41.10	226
Laundry	76.00	418
Maintenance	245.00	2,448
Office	25.20	377
PT/OT	10.50	58
Social Service Programs	6.50	36
Totals	404.30	$ 3,563

Schedule VII - Compensation Received From Other Nursing Homes

Michael Dubach - $196 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Ron Gasser- $478 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Keith Pflum - $106 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Warren Zahner- $416 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets

Investment in Related Entities	3,016,138

Sch. XVII - Income Statement, Line 28; Other Revenue

Developmental training	322,580
Farm income	800
Meals	1,782
	325,162

Schedule V, Line 39 - Ancillary Service Centers

Dental costs for 101 visits	$ 9,112

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	325,002
Loss from related parties	(128,077)
Estimated excess for year, Form 990, p.1, line 18	196,925

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	3,526,381
Add accrued wages a/o 6/30/01	91,090
Less accrued wages a/o 6/30/02	(83,051)
Add wages included in employee meal calculation	29,072
Cash basis salaries	3,563,492
FICA rate	0.0765
Calculated FICA	272,607
FICA per Sch XIX	263,808
Unknown variance	8,799

Sch. XX - General Information

12. Nurse Aide Trainer Wages:

Administrator	337
PT/OT	1,855
Activities Director	136
Head Cook	141
Maintenance	220
Nursing	21,012
Social Services	12,279
	35,980

14. A portion of office space is allocated to related entities based on number of beds

APOSTOLIC CHRISTIAN TIMBER RIDGE, #0016220

ATTACHMENT TO SCH VII A

Related Organizations:

Oakwood Estate, Morton, IL
Linden Estate, Morton, IL

Board of Directors for Apostolic Christian Timber Ridge, Oakwood Estate, and Linden Estate:

Edward Sauder, Chairman
John Knobloch, Vice Chairman
Dan Schumacher, Secretary/ Treasurer
Jerry Christensen, Director
Ron Gasser, Director
Jerry Kieser, Director
Keith Pflum, Director
Richard Steffen, Director
Warren Zahner, Director
Michael Dubach, Director

Note: The Board members are identical for all three organizations.

No members of the Board of Directors provided direct services to any of the nursing homes. No